FILED DEC 12 1950

**THE DIVISION OF HEALTH OF MISSOURI**
**STANDARD CERTIFICATE OF DEATH**

39585

State File No. 48

BIRTH NO. _____  REG. DIST. NO. 381  PRIMARY REG. DIST. NO. 45-15  Registrar's No. _____

| 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |
|---|---|
| a. COUNTY Sullivan | a. STATE Mo    b. COUNTY Sullivan 1050 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Milan | c. LENGTH OF STAY (in this place) 2½ mo. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Milan - Rural |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Simpson Hospt | d. STREET ADDRESS (If rural, give location) Polk Twp. |

| 3. NAME OF DECEASED (Type or Print) | a. (First) John | b. (Middle) William | c. (Last) White | 4. DATE OF DEATH (Month) 11 (Day) 30 (Year) 50 |
|---|---|---|---|---|

| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married | 8. DATE OF BIRTH 10-27-1879 | 9. AGE (In years last birthday) 71 | IF UNDER 1 YEAR Months 1 Days 3 | IF UNDER 24 HRS. Hours Min. |

| 10a. USUAL OCCUPATION Farmer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE Orangeville Texs | 12. CITIZEN OF WHAT COUNTRY? US |

| 13a. FATHER'S NAME James White | 13b. MOTHER'S MAIDEN NAME Mary L Harris | 14. NAME OF HUSBAND OR WIFE |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? No | 16. SOCIAL SECURITY NO. — | 17. INFORMANT'S SIGNATURE OR NAME Claude White   ADDRESS Milan Mo |

**18. CAUSE OF DEATH**
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Hemmorhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
1948

331X

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |

| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 1948, 19__, to Nov 30, 1950, that I last saw the deceased alive on Nov. 29, 1950, and that death occurred at 6 a m., from the causes and on the date stated above.

| 23a. SIGNATURE Ed Simpson (Degree or title) MD | 23b. ADDRESS Milan, Mo | 23c. DATE SIGNED 11-30-50 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Dec. 2-1950 | 24c. NAME OF CEMETERY OR CREMATORY Oakwood Cem. | 24d. LOCATION Milan Mo |

| DATE REC'D BY LOCAL REG. 12-4-50 | REGISTRAR'S SIGNATURE Mrs H.B Harris 320 45 | 25. FUNERAL DIRECTOR'S SIGNATURE Dwight Scheure   ADDRESS Milan-Mo |

(Licensed Embalmer's Statement on Reverse Side)

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____,

working under my personal supervision.

Student Embalmer No.........................

Signed_____ *Dwight Schoure*

Signed.............................
    Student Embalmer

Licensed Embalmer No. *2667*

P. O. Address_____ *Milan Mo.*

Note:   The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi
the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.